

APPENDIX C

DENTAL COVERAGEI. Enrollment Classifications

Dental coverage for a primary enrollee may include coverage for eligible secondary enrollees as defined in the Program.

II. Description of Benefits

Dental benefits will be payable, subject to the conditions herein, if an enrollee incurs a covered dental expense.

III. Covered Dental Expenses

Covered dental expenses are the usual charges of a dentist which an enrollee is required to pay for services and supplies which are necessary for treatment of a dental condition, but only to the extent that such charges are reasonable and customary charges, as herein defined, for services and supplies customarily employed for treatment of that condition, and only if rendered in accordance with accepted standards of dental practice. Such expenses shall be only those incurred in connection with the following dental services which are performed, except as otherwise provided in Section VII.B., by a licensed dentist and which are received while coverage is in force.

A. The following covered dental expenses shall be paid at 100% of the reasonable and customary charge:

1. Routine oral examinations and prophylaxes (scaling and cleaning of teeth), but not more than twice each in any calendar year. Up to three cleanings per calendar year will be allowed if there is a documented history of periodontal disease. Up to four cleanings per calendar year will be covered for two full calendar years following periodontal surgery.
2. Topical application of fluoride provided that such treatment shall be a covered dental expense only for enrollees under 20 years of age, unless a specific dental condition makes such treatment necessary.

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3. Space maintainers that replace prematurely lost teeth for children under 19 years of age.
 4. Emergency palliative treatment.
- B. The following covered dental expenses shall be paid at 80% of the reasonable and customary charge:
1. Dental x-rays, including full mouth x-rays once in any period of five consecutive calendar years, supplementary bitewing x-rays once in any calendar year and such other dental x-rays including, but not limited to, those specified in this paragraph, as are required in connection with the diagnosis of a specific condition requiring treatment.
 2. Extractions.
 3. Oral surgery.
 4. Amalgam, silicate, acrylic, synthetic porcelain, and composite, or other American Dental Association (ADA)-approved direct restorative materials that meet Program standards and are deemed appropriate by the carrier, to restore diseased or accidentally injured teeth.
 5. General anesthetics and intravenous sedation when medically necessary and administered in connection with oral or dental surgery.
 6. Treatment of periodontal and other diseases of the gums and tissues of the mouth.
 7. Endodontic treatment, including root canal therapy.
 8. Injection of antibiotic drugs by the attending dentist.
 9. Cosmetic bonding of eight front teeth for children 8 through 19 years of age if required because of severe tetracycline staining, severe fluorosis, hereditary opalescent dentin, or amelogenesis imperfecta, but not more frequently than once in any period of three consecutive calendar years.

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C. The following covered dental expenses shall be paid at 50% of the reasonable and customary charge:

1. Initial installation of fixed bridgework (including inlays and crowns as abutments).
2. Initial installation of partial or full removable dentures (including precision attachments and any adjustments during the six-month period following installation).
3. Replacement of an existing partial or full removable denture or fixed bridgework by a new denture or by new bridgework, or the addition of teeth to an existing partial removable denture or to bridgework, but only if satisfactory evidence is presented that:
 - a. the replacement or addition of teeth is required to replace one or more teeth extracted after the existing denture or bridgework was installed;
 - b. the existing denture or bridgework cannot be made serviceable and, if it was installed under this dental coverage, at least five years have elapsed prior to its replacement; or
 - c. the existing denture is an immediate temporary denture which cannot be made permanent and replacement by a permanent denture takes place within 12 months from the date of initial installation of the immediate temporary denture.

Normally, dentures will be replaced by dentures, but if a professionally adequate result can be achieved only with bridgework, such bridgework will be a covered dental expense.

4. Orthodontic procedures and treatment (including related oral examinations) consisting of surgical therapy, appliance therapy, and functional/myofunctional therapy (when provided by a dentist in conjunction with appliance therapy) for enrollees under 19 years of age, provided, however, that benefits will be paid after attainment of age 19 for continuous treatment which began prior to such age.

5. Services and procedures for the conservative diagnosis and treatment of temporomandibular joint (TMJ) dysfunction including, but not limited to, related oral examinations, consultations, x-rays, occlusal equilibration, diagnostic models and casts, temporary splints and orthotic appliances. Coverage does not include orthodontic treatment except as provided in App. C, III.C.4. above.
6. Repair or recementing of crowns, inlays, onlays, bridgework, or dentures; or relining or rebasing of dentures more than six months after the installation of an initial or replacement denture, but not more than one relining or rebasing in any period of three consecutive calendar years.
7. Inlays, onlays, gold fillings, or crown restorations to restore diseased or accidentally injured teeth, but only when the tooth, as a result of extensive caries or fracture, cannot be restored with an amalgam, silicate, acrylic, synthetic porcelain, composite, or other American Dental Association (ADA)-approved materials that meet Program standards and are used for direct filling restoration.
8. Implantology

IV. Maximum Benefits For Other Than Accidental Dental Injury

The maximum benefit payable for all covered dental expenses incurred during a calendar year commencing January 1 and ending the following December 31 (except for services described in Section III.C.4. and 5. above, and in Section XI below) shall be \$1,700 for each enrollee, with a maximum of \$1,600 applicable to covered dental expenses provided prior to January 1, 2005.

For covered dental expenses in connection with orthodontics (including related oral examinations), described in Section III.C.4. above, the maximum benefit payable shall be \$2,000 during the lifetime of each enrollee, with a maximum of \$1,800 applicable to covered expenses for services provided prior to January 1, 2005.

For covered dental expenses in connection with TMJ treatment described in Section III.C.5. above, the maximum benefit payable shall be \$2,000 during the lifetime of each enrollee.

V. Pre-Determination of Benefits

If a course of treatment can reasonably be expected to involve covered dental expenses of \$200 or more, a description of the procedures to be performed and an estimate of the dentist's charges must be filed with the carrier prior to the commencement of the course of treatment.

The carrier will notify the enrollee and the dentist of the benefits certified as payable based upon such course of treatment. In determining the amount of benefits payable, consideration will be given to alternate procedures, services, or courses of treatment that may be performed for the dental condition concerned in order to accomplish the desired result. The amount included as certified dental expenses will be the appropriate amount as provided in Sections III. and IV., determined in accordance with the limitations set forth in Section VI.

If a description of the procedures to be performed and an estimate of the dentist's charges are not submitted in advance, the carrier reserves the right to make a determination of benefits payable taking into account alternate procedures, services, or courses of treatment, based on accepted standards of dental practice. To the extent verification of covered dental expenses cannot reasonably be made by the carrier, the benefits for the course of treatment may be for a lesser amount than would otherwise have been payable.

This pre-determination requirement will not apply to courses of treatment under \$200 or to emergency treatment, routine oral examinations, x-rays, prophylaxes, and fluoride treatments.

VI. Limitations

A. Restorative

1. Gold, Baked Porcelain Restorations, Crowns and Jackets

If a tooth can be restored with a material such as amalgam, payment of the applicable percentage of the charge for that procedure will be made toward the charge for another type of restoration selected by the enrollee and the dentist. The balance of the treatment charge remains the responsibility of the enrollee.

2. Reconstruction

Payment based on the applicable percentage will be made toward the cost of procedures necessary to eliminate oral disease and to replace missing teeth. Appliances or restorations necessary to increase vertical dimension or restore the occlusion are considered optional and their cost remains the responsibility of the enrollee.

B. Prosthodontics

1. Partial Dentures

If a cast chrome or acrylic partial denture will restore the dental arch satisfactorily, payment of the applicable percentage of the cost of such procedure will be made toward a more elaborate or precision appliance that the enrollee and dentist may choose to use, and the balance of the cost remains the responsibility of the enrollee.

2. Complete Dentures

If, in the provision of complete denture services, the enrollee and dentist decide on personalized restorations or specialized techniques as opposed to standard procedures, payment of the applicable percentage of the cost of the standard denture services will be made toward such treatment and the balance of the cost remains the responsibility of the enrollee.

3. Replacement of Existing Dentures

Replacement of an existing denture will be a covered dental expense only if the existing denture is unserviceable and cannot be made serviceable. Payment based on the applicable percentage will be made toward the cost of services which are necessary to render such appliances serviceable. Replacement of prosthodontic appliances will be a covered dental expense only if at least five years have elapsed since the date of the initial installation of that appliance under this dental coverage, except as provided in Section III.C.3. above.

C. Orthodontics

1. If orthodontic treatment is terminated for any reason before completion, the obligation to pay benefits will cease with payment to the date of termination. If such services are resumed, benefits for the services, to the extent remaining, shall be resumed.
2. The benefit payment for orthodontic services shall be only for months that coverage is in force.

VII. Exclusions

Covered dental expenses do not include and no benefits are payable for:

- A. charges for services for which benefits are provided under other health care coverages;
- B. charges for treatment by other than a dentist, except that scaling or cleaning of teeth and topical application of fluoride may be performed by a licensed dental hygienist if the treatment is rendered under the supervision and guidance of the dentist;
- C. charges for veneers or similar properties of crowns and pontics placed on, or replacing teeth, other than the ten upper and lower anterior teeth;
- D. charges for services or supplies that are cosmetic in nature (except as provided in Section III.B.11.), including charges for personalization or characterization dentures;
- E. charges for prosthetic devices (including bridges), crowns, inlays, and onlays, and the fitting thereof which were ordered while the enrollee was not covered for dental coverage or which were ordered while the enrollee was covered for dental coverage but are finally installed or delivered to such enrollee more than 60 days after termination of coverage;
- F. charges for the replacement of a lost, missing, or stolen prosthetic device;
- G. charges for failure to keep a scheduled visit with the dentist;
- H. charges for replacement or repair of an orthodontic appliance;

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- I. charges for services or supplies which are compensable under a Worker's Compensation or Employer's Liability Law;
- J. charges for services rendered through a medical department, clinic, or similar facility provided or maintained by the enrollee's employer;
- K. charges for services or supplies for which no charge is made that the enrollee is legally obligated to pay or for which no charge would be made in the absence of dental coverage;
- L. charges for services or supplies which are not necessary, according to accepted standards of dental practice, or which are not recommended or approved by the attending dentist;
- M. charges for services or supplies which do not meet accepted standards of dental practice, including, but not limited to, charges for services or supplies which are experimental in nature;
- N. charges for services or supplies received as a result of dental disease, defect or injury due to an act of war, declared or undeclared;
- O. charges for services or supplies from any governmental agency which are obtained by the enrollee without cost by compliance with laws or regulations enacted by any Federal, state, municipal, or other governmental body;
- P. charges for any duplicate prosthetic device or any other duplicate appliance;
- Q. charges for any services to the extent benefits are payable under any health care program supported in whole or in part by funds of the Federal government or any state or political subdivision thereof;
- R. charges for the completion of any insurance forms;
- S. charges for sealants and for oral hygiene and dietary instruction;
- T. charges for a plaque control program;
or
- U. charges for services or supplies related to periodontal splinting.

VIII. Proof of Claim

The carrier reserves the right at its discretion to accept, or to require verification of, any alleged fact or assertion pertaining to any claim for dental benefits. As part of the basis for determining benefits payable, the carrier may require x-rays and other appropriate diagnostic and evaluative materials.

IX. Alternative Dental Coverage

- A. The Corporation may make arrangements for eligible enrollees to enroll for approved and qualified alternative dental coverages which may provide for benefits and/or copayments which are different from those specified in this Appendix. The Corporation's contributions toward coverage under such alternative dental coverage shall not be greater than the amount the Corporation would have contributed for dental coverage herein.
- B. At its option, the Corporation may implement a dental network under which coverage may be limited to covered services obtained from network providers and/or benefits may be reduced or eliminated for covered services obtained from non-network providers. At the Corporation's option, such a network may be substituted for the standard dental coverage under this Appendix, for alternative dental coverage, or both.

X. Definitions

As used in this Appendix, the terms identified below have the meanings stated.

- A. "dentist" means a legally licensed dentist practicing within the scope of such dentist's license. As used herein, the term "dentist" also includes a legally licensed physician authorized by license to perform the particular dental services such physician has rendered.
- B. "reasonable and customary charge" is defined in Article IV, Section 15 of the Program. However, for purposes of this Appendix "area" means a metropolitan area, a county or such greater area as is necessary to obtain a representative cross-section of dentists rendering such services or furnishing such supplies.

- C. "course of treatment" means a planned program of one or more services or supplies, whether rendered by one or more dentists, for the treatment of a dental condition diagnosed by the attending dentist as a result of an oral examination. The course of treatment commences on the date a dentist first renders a service to correct or treat such diagnosed dental condition.
- D. "orthodontic treatment" means preventive and corrective treatment of those dental irregularities which result from the anomalous growth and development of dentition and its related anatomic structures or as a result of accidental injury and which require repositioning (except for preventive treatment) of teeth to establish normal occlusion.
- E. "ordered" means, in the case of dentures, that impressions have been taken from which the denture will be prepared; and, in the case of fixed bridgework, restorative crowns, inlays, or onlays, that the teeth which will serve as abutments or support or which are being restored have been fully prepared to receive, and impressions have been taken from which will be prepared the bridgework, crowns, inlays or onlays.
- F. "temporomandibular joint (TMJ) dysfunction/disorder" refers to a disorder of the supporting and regulating structures of the jaws including changes in muscles, ligaments and nerves; these changes are generally reversible by time and/or treatment.
- G. "accidental dental injury" means an injury to sound natural teeth caused by external forces which occur as the result of a traumatic incident which is sudden and unforeseen and which are not ordinarily associated with chewing or the reasonable use of teeth in normal activity which results in the need for repair and/or replacement of dental structures.

XI. Accidental Dental Injury

For services obtained as the result of an accidental dental injury which occurs while the enrollee is eligible for coverage and enrolled, benefits in excess of the maximums as described in Section IV. are available for repair and/or care of sound natural teeth subject to the following conditions.

A. Benefits are available when:

1. services are covered under this Appendix (except for orthodontic treatment or treatment of

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temporomandibular joint dysfunction) or would have been covered under this Appendix in the absence of the frequency limitations provided in Sections III. and VI.;

2. the maximum benefits described in Section IV. have been exceeded;
3. the enrollee has sustained a covered accidental dental injury, which is verifiable and documented in the record;
4. services are the direct result of the accidental dental injury; and
5. services are provided within one year subsequent to the date of the accident except:
 - a. when acceptable evidence is presented to the carrier that unusual or special dental and/or medical needs prevented the provision of services within that time period; or
 - b. when the dental development of the injured enrollee is incomplete at the time of injury, in which event services must be provided no later than two years after full development is reached.

B. Benefits for covered services are subject to:

1. the reasonable and customary charges for repair and/or care of sound natural teeth;
2. a 20% copayment; and
3. a maximum benefit payment per enrollee of \$12,000 per qualified occurrence and per lifetime.

C. Coverage under this Section is not available for services for injury caused by normal wear and tear on the teeth or on a prosthetic dental appliance.